## TREATMENT REQUEST FORM (TRF)

Magellan Behavioral Health and its affiliated entities Human Affairs International, Inc., Green Spring Health Services, Inc., CMG Health, Inc. and Merit Behavioral Care Systems Corporation

Patient Information								Practitioner Information								
Patient's F	First Name							Pract	itioner ID	)#		Phon	e Numbe	r		
Patient's D	Date of Birt	th														
								Practitioner Name								
Membership Number Authorization Number								Address								
Authorization Number																
							First	Date Seen (t	his episodo	e of treatmen	t)	/	/			
Is the	patient on	mental hea	alth or che	emical depe	ndency sh	ort-term o	or long ter	m disabilit	y?	O Ye	es O	No				
Have	you comm	unicated w	ith the PC	CP or other	relevant h	ealth care	practition	ners about t	reatment?	OYe	es O	No				
	DSM-IV Multiaxial Diagnosis (please complete all five axes)															
AXIS I Dx Code																
AXIS II Dx Code .																
AXI	AXIS III Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the															
	condition(s) noted in Axis I or II? O No O Yes															
AXIS IV Severity of current psychosocial stressors  O None O Mild O Moderate O Severe																
			O Non	ie	O N	lild	0	Moderate		O Sever	e					
AXIS V:	GAF Sco	ore I	Highest Pa	ast Year			At first Se	ession			Curren	nt				
								Participation for Mineral Co.								
O Anti n	evolotio	O 4		Current M	ledication	ns (if not	t applica	ble, no res								
O Anti-psychotic O Anti-anxiety O Anti-depressant O Psycho-stimulant O Injectibles O Hypnotic O Non-psychotropic O Mood stabilizer/Anti-convulsant O Antabuse O Other																
	W10 AD-800 7000			*		SALES OF PARTY OF				MICH A MICH AND ADDRESS OF THE ADDRE						
		DI .	.1				Symptom		**							
		Please rate	Mild	nt's current Mod	Status on t		ptoms, if a	applicable.	If not app	olicable, no	Mild	Mod Mod	Severe			
Sel	Self-injurious behavior O O O							Н	Iomicidal	ideation	O	O	O			
	Suicidal ideation O O O							Substance use problems O				0 0				
				C	oncurren	t Auth H	Request (	number o	f session	s)					S 101-1111	
Length of time for requested sessions: O 1 month (or less) O 2 mo							months	hs O 3 months O 6 months				How many times have you seen the patient to date?				
	1	2	3	4	5	6	7	8	9	10	11	12	n the patie	nt to da	ite?	
90804	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
90805	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	
90806	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	
90807	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	
90847	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	
90853	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	
90862	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	
96100	. 0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	
Other	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	
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